New Jersey Department of Health and Senior Services
Division of Aging and Community Services

HOSPITAL PRE-ADMISSION SCREENING DISCHARGE*

Patient's Name _____ _____
Last *First*

Patient's Social Security Number _____

Community Choice Counselor _____

PAS Date _____ Track _____ # Months _____

Name of Hospital _____

City _____

Date Discharged _____ Date Expired _____

Discharged To _____

Address _____

_____

Submitted By _____ Date _____

*Form may be used to email, FAX or mail information or as written confirmation of discharge to be submitted to the Long Term Care Field Office.